Économie publique/Public economics

14 | 2004/1
Varia

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La concurrence dans le système de santé aux Pays-Bas

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Édition électronique
URL : http://journals.openedition.org/economiepublique/202
ISSN : 1778-7440

Éditeur
IDEP - Institut d'économie publique

Édition imprimée
Date de publication : 15 janvier 2005
ISBN : 36-26-44-X
ISSN : 1373-8496

Référence électronique
Ed W.M.T. Westerhout, « Competition in the Dutch Health Care System », *Économie publique/Public economics* [En ligne], 14 | 2004/1, mis en ligne le 05 janvier 2006, consulté le 24 avril 2019. URL : http://journals.openedition.org/economiepublique/202

économie publique

études et recherches

Revue de l'Institut d'Économie Publique

Deux numéros par an

n° 14 - 2004/1

IDEP

économie publique sur internet : www.economie-publique.fr

Centre de la Vieille-Charité

2, rue de la Charité – F-13002 Marseille

Imprimé en France.

La revue économie publique bénéficie du soutien du Conseil régional Provence-Alpes-Côte d'Azur

ISSN 1373-8496

Dépôt légal décembre 2004 – n° imprimeur 362644X

Competition in the Dutch Health Care System

Ed W.M.T. Westerhout *

Abstract

This paper describes the move towards a model of managed competition in the Dutch health care system. Although important policy changes have been implemented, a lot of work remains to be done. As regards managed care activities by insurers and mobility of people between different sickness funds for example, the results of policy changes thus far have been modest. The paper explains the slow progress in terms of the preferences of Dutch policy makers to avoid cost increases and prevent a reduction of the accessibility of medical care. Reforms will not come to a halt however. Indeed, the ageing of the population will command further reforms of the health care sector.

Introduction

The evolution of Dutch health care policies fits nicely in the framework proposed by Cutler (2002). Whereas in the eighties policy makers tried to curb the continuous growth in health expenditure mainly by policies of regulation, in the nineties the focus shifted more to introducing competitive elements in the health care system. This is not to say that from then Dutch policies pursued a model of pure competition: this would conflict with the principle of accessibility of medical care, which is highly valued by Dutch policy makers. Rather, the policy reforms aimed at introducing a model of regulated competition (Enthoven (1978, 1988)) in order to increase efficiency without sacrificing the solidarity between different medical risks.

Typical for the Netherlands are two features. One is that whichever policies are being introduced, they should not imply a risk of increasing health expenditure (and health insurance premiums). The other is that policy reforms should not

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imply a (partial) privatization of health care. These two additional restrictions may explain why the reform of the health care market in the Netherlands has taken a long time up till now and why we should not expect dramatic changes in policies or results in the coming years. The Dutch population is ageing like the populations in so many other countries however, making ultimately a reform of the health care system unavoidable. Because of the upward pressure on health care costs that ageing brings about, ultimately policy makers cannot escape to accept a lower degree of accessibility, either through increasing competition on health insurance markets or a (partial) privatization of health insurance schemes.

This paper describes the ideas behind Dutch policies that aim to make health care markets more competitive and how they have been put into practice. It sketches that policy changes have been rather slow. This may reflect the fear that more drastic policy changes would lead to a cost explosion or would severely endanger the solidarity between different medical risks. It argues that the prospect of ageing will unavoidably imply that health insurance contribution rates are reduced, either by paying more attention to the efficient provision of health care services or by privatizing part of health insurance.

The structure of this paper is as follows. Section 2 briefly describes the structure of Dutch health insurance schemes. Sections 3 and 4 discuss the policy changes that have been implemented in the Netherlands and their effects on the health insurance system. Section 5 adopts a political-economy perspective to explain why the health care system has been reformed quite slowly. Section 6 concludes.

1. The Dutch health insurance scheme

This section discusses the Dutch health insurance scheme on a very global level. [1] The scheme consists of three pillars. Basically, the first pillar (AWBZ) covers long-term care services [2], whereas the second pillar schemes cover expenditure on short-term care services. [3] The relatively small third pillar covers services that are considered to be more luxury. [4]

The first-pillar insurance scheme is a public scheme with mandatory insurance and is financed by a combination of income-dependent premiums and co-payments. The second-pillar insurance scheme falls into three parts: a public

1. For a more detailed description, see Westerhout (1999).
2. This includes nursing home care, institutional care for mentally and physically handicapped persons and hospital care exceeding one year.
3. This includes services by general practitioners, medical specialists and hospital care up to one year.
4. This includes luxury hospital services , but also dental care for adult persons.

scheme that is mandatory for those with income below a certain threshold (ZFW), a set of voluntary private schemes for those with age below 65 who are not allowed to join the public scheme and, finally, a voluntary public scheme for 65+ persons who are not allowed to join the ZFW (WTZ). Two types of community-rated premiums finance the ZFW, namely income-dependent premiums and nominal (*i.e.* income-independent) premiums. The private scheme draws on nominal premiums in combination with co-payments (mostly deductibles). The WTZ is financed by community-rated premiums and taxes. Third-pillar insurance is voluntary and, like the private second-pillar schemes, financed by a combination of nominal premiums and co-payments.

The Dutch health insurance scheme is more public than private. Using 1997 figures, only about 12.5 % of health expenditure is covered by private schemes and 87.5 % by public schemes.[5] The distinction between public and private is not very informative about the organization of insurance schemes, however. For a discussion of competitive elements in Dutch insurance schemes, the regulations governing public and private insurance schemes are more relevant. Indeed, the next section will show that although the ZFW scheme has always been regarded a public scheme, it has undergone many transformations in the last 12 years.

2. The content of the policy reforms

Already in 1988, the Dutch government decided to move its health care system towards a model of managed competition. The Dekker plan aimed at the introduction of a national health insurance scheme, covering both long-term care and health care services. The main reason to go for the model of managed competition was that it promises cost reduction without hampering the accessibility of health care. Behind this is the aim to limit the increases in health insurance contribution rates. Income-dependent health insurance contributions distort the labour market, just like income taxes do, and contribute to employment and output losses. Obviously, (partial) privatization would be a way to reduce income-dependent health insurance contribution rates.[6] However, this would conflict with the principle of accessibility of medical care, a principle that is so highly valued in the

5. If the WTZ were characterized as a private scheme, then the share of private schemes would be considerably larger: 19 rather than 12.5 %. Although the WTZ is administered by private insurers and participation is voluntary, the WTZ scheme may better be viewed as a public scheme since premiums are community-rated and acceptance is obligatory, just like in the two other public schemes, the AWBZ and the ZFW.

6. The scope of public insurance can be reduced in a number of ways: by eliminating certain types of medical care from insurance packages, by introducing co-payments or by introducing nominal premiums.

Netherlands, that privatization to a more than trivial degree has not occurred.

On one aspect, the Dekker plan failed immediately: policy makers abandoned the idea to change the first and second pillar of health insurance simultaneously. Instead, they decided to go for a stepwise reform, beginning with the ZFW, the major public part of second-pillar health insurance. Up till now, schemes other than this ZFW have been left unaffected. However, the current government will introduce a basic insurance scheme in 2006, basically integrating the three parts of second-pillar insurance and extending considerably the scope of the model of managed competition (CPB (2003)).

The changes implemented in the ZFW scheme fall into four parts: the financing of the ZFW, policies reforming provider markets, price policies, and policies reforming insurance markets. We will discuss the changes in these four parts successively.

2.1. The financing of the ZFW

Traditionally, the sickness funds that administer the ZFW were reimbursed on a retrospective basis. 1993 saw the introduction of a prospective payment scheme, which aimed to create incentives for sickness funds for an efficient delivery of medical services. This transformation was not a big bang, but occurred very gradually. With the introduction of prospective payments, also a transfer scheme was introduced that paid sickness funds an additional amount when their costs exceeded the prospective payment amount. As this additional amount is a fraction (between zero and one) of the excess of costs over the amount of prospective payments, the new scheme is actually a mix of a prospective and a retrospective scheme. Gradually, this fraction has been lowered from 97 % in 1993 to 47 % in 2004, turning the payment scheme more and more into a pure prospective one (Van de Ven *et al.* (2004)).

The prospective element of the new payment scheme includes corrections for risk factors that are exogenous for sickness funds. There are two reasons for this. First, it would be unfair if sickness funds that happened to have an under-representation (over-representation) of bad risks to make profits (losses). Second, sickness funds would have an incentive to reduce the quality of services they provide to those insured for which they expect to make losses. Therefore, the prospective element of the new payment scheme adjusted for risk factors such as age and gender. Over time, the payment scheme has been changed frequently. In particular, risk factors have been added in order to improve the risk adjustment properties of the payment scheme. In 2001, the determination of prospective payments to individual sickness funds rests on age, gender, degree of urbanization, insurance ground (*e.g.*, whether the insured is a wage earner or an unemployment

benefit recipient) and type of care (*e.g.*, outpatient care or inpatient care) (Lamers *et al.* (2003)). In 2002, information derived from prescribed drug usage was added to the set of risk adjusters (Van de Ven *et al.* (2004)).

2.2. Policies reforming provider markets

In 1992, the rule that stipulated that sickness funds should have a contract with all providers of medical services in their region was abolished, but only for the non-institutional providers like physiotherapists. For institutional providers like hospitals, the intention is to do the same, but this has not been realized yet. Also important for provider markets is that in 1998, a policy change has been implemented that aims to strengthen competition policies in the Netherlands. This policy change is general and thus is relevant for health care provider markets as well.

Policies regulating the supply of medical care have remained largely unchanged. Policies that restrict the number of persons that are allowed to study medicine at university have been kept in place and provider organisations have continued to self-regulate the market. Policies that regulate hospital capacity are no longer un-discussed however. The current government is working on abolishing regulations that dictate the investment decisions of hospitals.

2.3. Price policies

Before 1992, the prices for medical services were set by a central authority. As part of the 1992 reforms, prices for services provided by non-institutional providers were deregulated and the previous prices were transformed into maximum prices. For hospitals, there are plans to deregulate prices in the future. As a first step, all medical services that are provided by hospitals have in the last few years been classified under a DRG system. The next step will entail price deregulation for 10 % of hospital production. But this has been postponed on two occasions already with half a year.

2.4. Policies reforming insurance markets

Before 1992, sickness funds were regional monopolies: they could only enroll those who lived in the area in which the fund was located. In 1992, this rule was abolished, allowing sickness funds to compete for subscribers. First, enrollment periods were bi-annual, but since 1997, they are annual.

3. The results of the policy reforms

As shown in the previous section, financial incentives for sickness funds for an efficient delivery of care have gradually increased over time. Yet, the mobility of insurees across sickness funds has not increased significantly, despite the fact that the variation in nominal premiums across sickness funds has increased considerably.[7] As shown previously, policy reforms in other fields have been partial and slow. In particular, policies regulating the supply of medical care have not undergone significant changes. This has led to a shortage of supply in a number of markets. That this undermines the bargaining power of insurance companies is obvious.

Together, these factors may explain why we have seen few sickness funds starting to undertake managed care activities. Sickness funds have not developed policies to monitor the activities of doctors and have been reluctant to bargain more aggressively about prices of medical services.

4. The benefits and costs of managed competition

The model of managed competition may help to achieve a higher level of efficiency than otherwise can be obtained. The model has some disadvantages as well, though. One is that the risk adjustment in insurance payment schemes will never be perfect. Although it is possible to eliminate a large part of the variation on costs that are exogenous to insurance companies, full elimination will never occur. This means that the payment scheme will always hurt those companies that have an over-representation of bad risks and that incentives for companies to lower the quality of services for these bad risks will remain (Douven and Westerhout, (2000)). In particular, the incentives to lower the quality of medical services are stronger the more prospective is the financing scheme for sickness funds.

Another drawback is that if quality is poorly observed by the insured, insurers have an incentive to reduce quality in order to economize on costs (Dranove and Satterthwaite (2000)). The study of Propper *et al.* (2004) for the UK indeed found a negative effect of competition on quality, be it that the effect was rather small. The argument holds even more strongly if government policies make consumers more price sensitive by increasing the transparency of insurance markets.

7. Schut and Hassink (2003) report that the standard deviation of the nominal premium increased from 1.2 (compared to a mean of 0.6) in 1995 to 27.9 (compared to a mean of 7.0) in 1999.

A third argument against managed competition is that the government does no longer have direct control over the volumes and prices and therefore the level of aggregate expenditure. The outcome of negotiations between insurers and providers of medical services may be a lower or higher level of expenditure. In particular, if there are few providers or if providers form cartels, insurance companies may find it difficult to set good bargains and the outcome may be higher aggregate health expenditure than under regulation policies.

The aim of the introduction of the model of managed competition in the Netherlands is to obtain a higher level of efficiency, a lower level of aggregate health expenditure and lower health insurance contribution rates. One can view the slow evolution of the sickness fund financing scheme from a retrospective scheme towards a prospective scheme as a reflection of the fear that insurers will start making efforts to select good medical risks. The slow progress in making insurance markets more transparent may similarly be explained from the fear that this will increase the efforts undertaken by insurers to lower prices by reducing quality. The reluctance of the government to deregulate supply policies may reflect the fear that an increase of supply will not be dominated by the effect on the bargaining position of insurance companies and will therefore raise health expenditure.

5. Concluding remarks

A number of factors may explain the slow progress towards making the health care system in the Netherlands more competitive. Can we expect reforms to come to a standstill? The answer is negative. In particular, ageing of the population increases the attractiveness of policy reforms that aim at reducing the level of health expenditure. Ageing will increase health care expenditure and reduce labour market participation. Both factors contribute to the expectation of an increasing health insurance contribution rate. Elsewhere, I have argued that this has three effects (Westerhout (2004)). First, it aggravates labour market distortions. Second, it aggravates a number of moral hazard distortions. Thirdly, increasing transfers from young healthy generations to old and unhealthy generations jeopardizes intergenerational solidarity. For all these reasons, it becomes more attractive to reduce the level of health expenditure by bringing in more competitive elements in health care schemes.

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